WOC Complex Plan of Care

Name: _____Janella Bryant_____Date: _____02/10/25_____

Clinical Focus: Wound ____ Ostomy ___ Continence __X__

Number of Clinical Hours Today: __9__

One complex journal is required for *each specialty in which you are enrolled/registered.* This assignment evaluates the transition from bedside nurse to that of a specialist/consultant. Critical thinking skills and understanding of evidence based, best practices should be evident. Rationales should be cited and referenced using current APA formatting.

Choose a patient from your clinical experience that exhibits multiple care needs allowing for development of an expanded, holistic plan of care. It is recommended this complex plan of care be your last journal for each specialty allowing for incorporation of previous instructor feedback. Reach out to your Practicum instructor for any questions.

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
74y female with PMH of HTN, HLD, CAD, MI s/p 3 stents, T2DM, CDK, CVA, anemia, obesity (BMI 30-35), h/o colon CA s/p surgical resection endometrial adenocarcinoma with mets to the liver, mild malnutrition with TPN dependence. Surgeries includes TAH/BSO/ PLND, c/b enterotomy and necrotizing skin infection s/p multiple washouts, now with enterocutaneous fistula. Pt was seen in the ostomy clinic for high out fistula to LLQ with external fecal collection device and with severe skin IAD r/t inadequate pouch seal despite several attempts to correct this issue. Pt is seen in clinic three times a week for pouching and skin care.	Labs from 12/5/24 WBC: 7.75 (4-11) HB: 8.7 (13-17) HCT: 27.3 (40-52%) PLT: 185(150-400) NA: 135 (135-145) K: 3.9 (3.5-5) CHLOR: 100 (95-105) CO2: 25 (23-29) BUN: 26 (8-21) CREAT:1.63 (0.8-1.3) GLUC: 267 (65-110) MG: 1.8 (1.5-2)

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
	Pouching device and surround		Damage to skin is directly related

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Fecal incontinence (FI) Leaking large amounts of yellow liquid stool from ABD fistula. Currently the fistula is pouched using a Eakin horizontal fistula pouch. Several attempts to provide convexity and attempts to fit pt alternative pouching systems to prevent incontinence has been unsuccessful. **Abdominal:** round, soft and concave, with many dips and folds. Old scars in proximity of the fistula. **Skin:** abdominal skin not in proximity of the fistula is noted to be intact, however, skin folds are moist, and yest smell observed. **ET perifistular skin**: erythematous denuded circumferentially and into skin creases surrounding the fistula and along the left side of abdomen. **Current fistula management**: Hollihesive wedges and strips were in place to create convexity. Eakin pouch remained in place with Mefix tap surrounding slight leakage observed	flange and tape was removed with adhesive remover. The push- pull technique was used. Suction held in place while skin care was provided with care using PH balanced soap the area was gently washed. Then the skin was rinsed with water and dried. Abdominal skin folds were cleaned as well. Domeboro was applied to the perifistular skin area. This was left in place to soak for 15 mins. Stoma powered was then applied to denuded areas with excess brushed away. 3M no sting skin barrier film was applied. Convexity was applied in the usual manger with additional stoma paste added. Eakin pouch attached and secured with Mefix tape and elastic barrier strips. Expected wear time 1-2 days. **Alternative products:** • Stoma power using the crusting procedure • Anti-fungal powder for Candidiasis seen under skin	Improvement to perifistular skin and skin folds. No further skin breakdown/IAD. Pt reports temporary relief in skin irritation with the use of domeboro prior to dressing changes. Pouching system showing no signs of leakage within 2 day time range.	to the time spent in contact with enzymes in stool. Prompt cleansing decreases the risk of further skin breakdown (Thayer & Nix, 2022). Frequent cleansing with soap and water can cause skin irritation. Instead, a no-rinse pH balanced cleanser should be used. Gently drying with a soft cloth prevents mechanical damage to skin. Moisture barrier creams prevent feces from penetrating the skin and causing damage (Thayer & Nix, 2022).

around 5 o' clock. Current wear time: 1 day. Due to high volume fistula, suctioning needed during changes, thus requiring two nurses. **Pain:** Pt reports no pain at time of assessment. **Mental status:** Pt shows some frustration with leakage and states it lowers her quality of life. Pt stated that she is often concerned with leakage, and it prevents her from leaving the house. She also stated that the smell from the fistula is bothersome and causes her embarrassment. **Nutritional needs:** Pt reports that she eats foods every other day. Pt is a type 2 diabetic and is also supported by TPN. Pt stated that she decreases her po intake out of fear of increase stool output and increase risk of fecal incontinence.	folds. • Coloplast fistula and wound management system. • Belted pouches with fistula solution devices. • Drain hook to low suction if available. • The use of Hollister Adhesive ring. Offer supportive care and reassurance to patient regarding the leakage and odor. Addition products added to pouching change to help with longer adhesive and decrease leakage. Pt educated about odor control additives and techniques to help decrease odors. Reinforce education on high fiber foods to thicken stool: bananas, nuts, brown rice, applesauce, and oatmeal. As well as fiber supplements to thicken/bulk stools. Continue TPN as ordered.	Pt receptive to supportive care offered by staff and pouch changes are offering more wear time and less leakage Odor decreased with pouching additives and diet adjustments. Decrease in the amount of liquid stool output.	Special attention and support must be given to patients with fistulas because they often report feeling loss of control and embarrassment (Nix & Bryant, 2022). Education with teach back involving the patient and family is important as well as setting realistic expectations on goals. Care is always patient specific (Nix & Bryant, 2022). Adequate nutrition and dietary support are especially important for patients with high volume fistulas r/t the increase risk of electrolyte loss and to assist with thickening of stool to slow down output ((Nix & Bryant, 2022).

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Diabetic: On TPN and oral feedings. BS range between 150-250 at times	Continue to self-monitor and record blood sugars using prescribed medication as prescribed.	Patient has been avoiding foods, drinks and medications that contribute to lose stool and reports an increase of fiber rich foods. Blood sugar levels WNL for pt specific POC and dietician recommendations. .	Caffeine, alcohol, greasy foods, and spicy foods, increase gastric motility, worsening FI. While Fiber rich food thicken loose stool and slow down GI motility (Nix & Bryant, 2022). Hyperglycemia is a intrinsic factor that affects wound healing. Although T2MD is modifiable, it still increasing the risk that a wound will stall and become chronic (Beitz, 2022).

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Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	2		
Assessment	Describe assessment findings	6		
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6		
	Wound and Continence Case Study Journal: Using the Braden scale, assess for pressure injury risk. **You must submit your completed Braden risk assessment with your care plan.	5		
Planning	Formulate a comprehensive management plan based on the assessment and the specialty (wound, ostomy, or continence) needs. **Wound and Continence Case Study Journal:** Include specific Braden sub-scale scores	12		
	Propose alternative products. Include generic & brand names	4		
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6		
Rationale	Explain the rationale for identified interventions	6		
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1		
	Proper grammar & punctuation used	1		
	References: See the course syllabus for specific requirements on references for all assignments	1		
	Total Points 80 % or higher is required to pass. **Minimum scores**: Ostomy: 36/45 Wound and Continence: 40/50			

Additional comments:

Reviewed by: _____ Date: _____

References

Beitz, J. (2022). Wound healing. In L. McNichol, C. Ratliff, S. & Yates. (Eds.), *Wound, Ostomy and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 39-55). Wolters-Kluwer.

Nix, D., & Bryant, R., A. (2022). Fistula management. In J. Carmel, J. Colwell, & M. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp. 283 -315). Wolters Kluwer.

Thayer, D., & Nix, D. (2022) Incontinence- associated dermatitis. In J.M. Ermer-Seltun, & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp.364-381). Wolters Kluwer.